QUÉBEC'S SYSTEM OF HEALTH AND SOCIAL SERVICES

Québec

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This publication of the ministère des Affaires sociales is designed to provide a global view of Québec's health and social service system. Although many specialized documents offer the same information in more detail, their diffusion is somewhat limited. This booklet is original in that it takes a comprehensive look at the history and the organization of our sociosanitary system.

"Québec's System of Health and Social Services" is an important source of information for the personnel of the Social Affairs network, the population of Québec and visitors from other countries. Readers who wish to obtain more detailed statistical data can refer to an appendix which is published separately.

I should like to thank all those who have contributed to the preparation of this publication. The interest readers take in it will be their recompense.

Jean-Claude Deschênes
Deputy Minister

TABLE OF CONTENTS

The historical context

Emergence of a policy 9
Beginnings of a reform: the 1960s 10
Reform: the 1970s 11
Consolidation 11
Federal Government Influence 12

The population

Demographic characteristics 15
Socio-economic characteristics 17
Habits 19
Health characteristics 20

The sociosanitary system

The system's foundations 29
The ministère des Affaires sociales (MAS) 30
The Régie de l'assurance-maladie du Québec (RAMQ) 30
The Social Affairs network 31
Community organizations 33
Other intervening parties 34

Resources

Human resources 41
Health professionals paid by the Régie de l'assurance-maladie du Québec 41
Salaried personnel of the Social Affairs network 42

Material Resources 46
Establishments 46
Beds and reception places 47

Costs

Social Affairs and the whole of public spending 51

Spending by the ministère des Affaires sociales 52
By type of establishment 52
Areas of activity 53
Programs administered by the Régie de l'assurance-maladie du Québec 54

Appendices

List of tables 65

List of figures 66

List of acronyms used 67

Statutes administered by the Minister of Social Affairs 68

1

THE HISTORICAL CONTEXT

Québec's current social policy is the result of a long process of evolution in the health and social services sectors. The first outlines of the desire for organizing health and social welfare were manifested well before 1960. However, since this time and over the decade following it, a number of events predicted significant changes which occurred from 1970 onwards.

Emergence of a policy

Under the French regime and during the 19th century, hospitals and care for the needy were maintained and financed by municipalities, parishes and religious communities through government grants, charity campaigns and parish revenues. In addition to running most health and social aid institutions, religious communities saw to the training and employment of para-medical and social staff.

However, the provincial government was not long in intervening in the field of public health with the creation, in 1834, of the first hospital founded by the State and run by laymen, namely, the Hôpital de la marine. Then, the Public Health Act, adopted in 1886, created the Board of Health in 1887. This body came to oversee, as it were, municipal health offices hereby marking the beginning of a series of legislative and financial interventions by Québec's provincial government.

In 1922, the Board of Health was replaced by the Provincial Bureau of Health following the adoption of the Public Assistance Act in 1921 aimed at making municipalities responsible for hospitalizing their needy. Costs were divided equally among the government, the municipalities and charitable institutions.

The health units created in 1926 were the first public health and preventive medicine organizations in Québec. From 1930 onwards they replaced the local boards of health.

The Health Department (Ministry) created in 1936 was responsible for supervising the application of legislation on public health, public assistance, the mentally ill, and the inspection of hospitals and other charitable institutions. Other functions were added, namely, promoting the development of public health, cooperating with the Government of Canada to facilitate the application of federal public health laws within the province, conducting scientific studies on public health and finally, compiling annual statistics on births, marriages, deaths and causes of death.

In 1941, the Health Department became the Health and Social Welfare Department and, in 1944, it was divided into two separate entities : the Health Department and the Welfare Department. That same year, an act authorizing the provincial government to establish a family allowances system and to pay benefits to families with children was adopted. Two years after its creation, the Social Welfare Department was replaced by the Welfare and Youth Department which, in 1961, would become the Department of Family Affairs and Social Welfare.

The 1950s were a fertile period for the future of public health and social security. The Canadian government established two measures of great importance for the social and health reform of the 1960s, namely, unemployment insurance in 1956 and hospital insurance in 1957.

Beginnings of a reform: the 1960s

The 1960s marked a turning point in the field of health and social welfare in Québec. Human and physical resources, programs and services were still being developed in a manner that revealed the lack of a comprehensive view of things and therefore of an overall policy; nevertheless, certain elements were beginning to take shape.

Legislative structure

A number of laws adopted during this decade marked Québec's social development.

In 1960, the provincial legislature adopted the Hospital Insurance Act. Beginning January 1, 1961, hospital services were free in Québec, that is, the government's responsibility.

In 1965, the Québec Pension Plan Act was passed hereby starting up a program of social security. In 1966, the Act respecting industrial accidents and the Act respecting medical aid were adopted. During the summer of 1969, another important event occurred. The Régie de l'assurance-maladie (Québec Health Insurance Board) was established. This new agency was responsible for setting up the administrative structure required for introducing the health insurance plan.

Finally, in December 1969, the Social Aid Act was adopted. This Act represented an important step towards an overall policy for Québec by authorizing the granting of social benefits to citizens unable to provide for themselves.

Analytic structure

During the 1960s, two committees particularly influenced the general orientation of public powers in the social welfare sector. These were: the Study Committee on Public Assistance (Boucher Committee) and the Commission of Inquiry on Health and Social Welfare (Castonguay-Nepveu Commission).

In its 1963 report, the Boucher Committee recommended that the government take over the social assistance activities hitherto under the responsibility of the Church, the family, and individuals as well as charitable organizations and volunteer groups.

The Comité Boucher insisted on the need for Québec to provide itself with an overall economic and social policy permetting a new administrative integration of policies related to labour, education, health and social welfare. The Department of Family Affairs and Social Welfare could not bring about corrective measures alone.

November 1966 marked the establishment of the Commission of Inquiry on Health and Social Welfare chaired first by Claude Castonguay until March 1970 and then by Gérard Nepveu beginning in April on the same year. The Commission's mandate was to conduct an inquiry on all fields of health and social welfare.

To begin with, the Commission submitted to the government a comprehensive social security plan and outlined the fundamental elements of social development: health, social services and income security. Secondly, it defined a sociosanitary system which, based on a coherent social philosophy, would completely shape the organization of Québec's health services and social services. For example, passing from the concept of public health to that of community health illustrates well the new dynamic, innovative philosophy proposed for distributing services.

Reform: The 1970s

From then on, social affairs constituted the cornerstone of an overall social development policy. Early in 1970, a new social development strategy emerged from the measures and activities of previous years.

It was then realized that this badly needed reform could take place only if based on a comprehensive concept of social services, health services and income security. This meant new laws and new administrative structures.

The new ministère des Affaires sociales, created under the Social Affairs Department Act assented to in December 1970, was the centre of the reform and, at the same time, responsible for carrying it out. By combining the health and social welfare sectors, Québec's lawmakers intended to build a framework favourable to social development. The new ministère des Affaires sociales resulted from the merging the Department of Health and the Department of Family Affairs and Social Welfare.

While supervising the integration of both departments and the administrative reorganization, the Minister's main task was to prepare an income security policy and develop coordination and control mechanisms for health and social welfare institutions.

From this time onward, a series of laws and regulations specified the legislative structure including the social mission. The Health Insurance Act (1970) and the Act respecting health services and social services (1971) defined the main parameters. The former permitted financial accessibility to medical care, oral surgery and optometric services, since they were free of charge. The Act respecting health services and social services extended this concept since it underlies a policy of universal accessibility to complete, continuous, complementary and high-quality care and services. Geographic accessibility to this care and these services was of fundamental importance. Furthermore, this Act was aimed at implementing a body of health services and social services, thus facilitating the elaboration, on local and regional levels, of programs taking into account the interrelations between health problems, social problems and citizens' economic difficulties.

Subsequently, the Office des professions and the Commission des Affaires sociales were created. Several acts regarding the protection of groups of citizens were adopted: Public Health Protection Act, Mental Patients Protection Act, Youth Protection Act and an Act ensuring human rights. A family allowances plan was also introduced by the Québec government following the example of the federal government. We should also add the Act respecting child daycare services and the Act respecting industrial health and safety.

In 1974, the department's administrative structure combined seven branches including Planning and Programming in the aim of coordinating and rationalizing the various care-giving establishments into one comprehensive integrated system. Planning, ranking establishments, care and decisions and coordination between the various levels implied the concentration of power.

Consolidation

A number of years ago, the concept of an integrated, coordinated, not to mention hierarchized, body of health services and social services gave way to the view of a complex sociosanitary system where several actors, each with its own rationale, would compete with one another. This more realistic view of the dynamics of our sociosanitary system also corresponded to a period where the terms reallocation, cutbacks and rationalization were heard more and more. Notably, this consolidation was translated by numerous legislative changes found in the Act respecting health services and social services (Bill 27).

In recent years, the ministère des Affaires sociales has reached the essential phase of consolidating and rationalizing its public health and social service interventions with a view to establishing complementarity between establishments. Increased health costs, juxtaposed with budgetary restrictions and personnel cutbacks dictated by the last economic crisis, force the ministère des Affaires sociales to tightly manage public funds.

The department retains the political and administrative authority permitting it to supervise the development of the two axes of its policy, health and social services, and hereby

to accomplish its twofold mandate. The latter consists of drawing up and coordinating Québec's main policies and overall social development programs and assessing health services and social services to ensure an adequate distribution of these services throughout the province. Especially since 1981, a number of these mandates were entrusted to regional health and social services councils (RHSSC) whose responsibilities and powers were extended.

Federal Government Influence

To understand the structure of social programs in force in Québec, we must remember that since 1867 Québec has been a member of the Canadian Confederation. Unlike a unitary state, one belonging to a federation must share its powers according to varying criteria.

The field of Social Affairs does not escape this rule of sharing. Although the National Assembly has very extensive powers in this area, it cannot legislate on all social programs. Some of them, like unemployment insurance, come under the jurisdiction of the federal government.

Constitutionally, two fundamental aspects must be considered in governmental interventions in social affairs, namely, the sharing of jurisdiction between the federal and provincial governments and federal-provincial agreements developed within the scope of the Constitution.

Sharing jurisdiction in health services and social services

The federal government may intervene directly, but not completely, in the area of health services and social services through certain powers regarding the military, Native Peoples and young offenders and certain specific sectors (quarantines and marine hospitals). Furthermore, since the adoption of the Canadian Health Act (C3), it is able to intervene virtually directly in the health sector with the full force of financial sanctions and the new power to make the provinces pay.

Federal-Provincial Agreements

In 1957, the Canadian government adopted the Hospital Insurance and Diagnostic Services Act. This Act guaranteed that the federal authority would finance provincial hospital insurance programs in a proportion of 50%. Québec was opposed to this type of agreement and claimed a transfer of fiscal resources. This is why it joined the plan only in 1961. In 1964, the Canadian government offered the provinces the possibility of funding hospital insurance and social aid programs through fiscal transfers in the form of equalization payments. Only Québec took advantage of this offer under the Established Programs Act.

Legislation was then enacted to finance health insurance. In 1966, the federal government began contributing to health insurance plans. It adopted the Medical Care Act. As in the case of hospital insurance, Canada assumed 50% of provincial expenditure.

Since 1977, the financing of these programs has been covered by the Established Programs Financing Act. However, the federal contribution is now based on the costs of the program for the 1975-1976 reference year. Moreover, the provinces must comply with the financing conditions stipulated in the Canadian Health Act which in spring 1984 replaced the Hospital Insurance and Diagnostic Services Act. As a rule, laws adopted by the provinces must respect the following principles: complete coverage of services, universal application of programs, uniform performance of services and reasonable accessibility to them.

For social services, the Canadian government contributes to funding existing programs through the Canada Assistance Plan. Once again, Canada assumes 50% of the cost. By establishing certain conditions related to sharing the expenses of establishments providing services to beneficiaries, the federal government exerts a certain amount of influence on the nature of services and their distribution.

Although federal government intervention in the field of social affairs remains significant because of the revenue available to it, Québec's actions nevertheless continue to retain their dynamic, innovative character.

2

THE POPULATION

This chapter traces a demographic, socio-economic and sociosanitary portrait of Québec's population.

Demographic Characteristics

On July 1, 1961, Québec had a population of 5 259 000. Twenty years later, its population is estimated at 6 438 000, a 22% increase. In 2001, the projected population will be 6 726 000 which represents a 4% increase in 20 years. This remarkable slowdown in population growth directly affects the population's structure by age (Figure 2.1). This is in fact a radical transformation. In 1961, the age pyramid was that of a young population: 35% of Québec's residents were under 15 years, 5,8% were over 65. In 1984, the proportion of young people under 15 was only 21,1%. This phenomenon can be explained mainly by the fact that in 1961, women of child-bearing age had an average of 3,8 children compared to 1,6 in 1981. The fertility level projected for 1984 is 1,5 children per family.

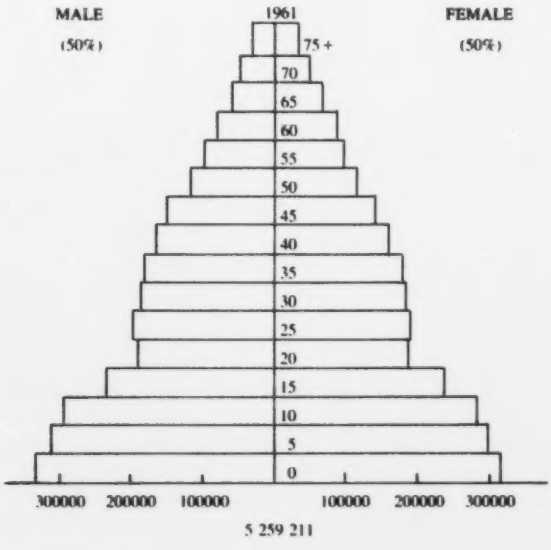
The ratio of the number of people aged 0 to 14 years and 65 years or more over the number of people whose age varies from 14 to 64 gives us the dependency rate[1]. This ratio dropped from 70,2% in 1961 to 43,9% in 1981* signifying that family responsibilities decreased considerably over twenty years. Finally, the dependency ratio varies little between 1981 and 2001, dropping from 43,9% to 42,7%. However, its composition differs significantly since in 1981 people aged 65 or over represented 29% of dependents compared to 43% in 2001. Québec's population is aging rapidly.

It is easy to imagine the repercussions of these demographic changes on the sociosanitary system. The needs of pregnant women and young children are clearly different from those of adults of working age. Similarly, the needs

(1) This is a rough indicator which ignores the average age of persons entering or leaving the labour market as well as the level of unemployment and social aid, which will most likely differ greatly between 1961 and 2001. Nevertheless, the indicator's range illustrates our remarks.

* In 1984, this percentage remained practically unchanged.

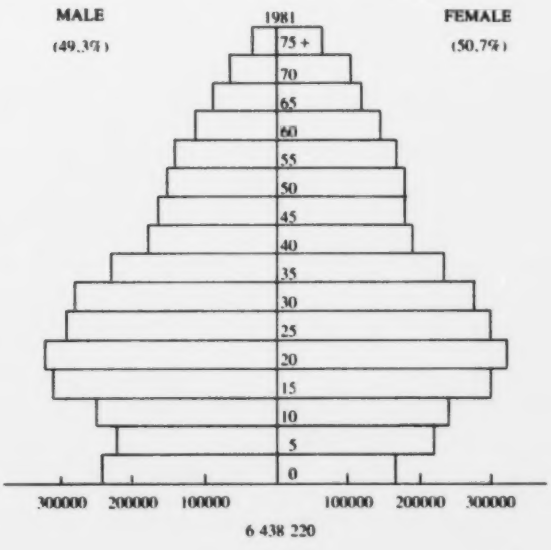
Figure 2.1 Age Pyramids, Québec, 1961, 1981, 2001



5 259 211

AGE	POPULATION (in 1 000s)	BREAK-DOWN
0 -14	1863	35.4%
15 -64	3090	58.7%
65 et plus	306	5.8%

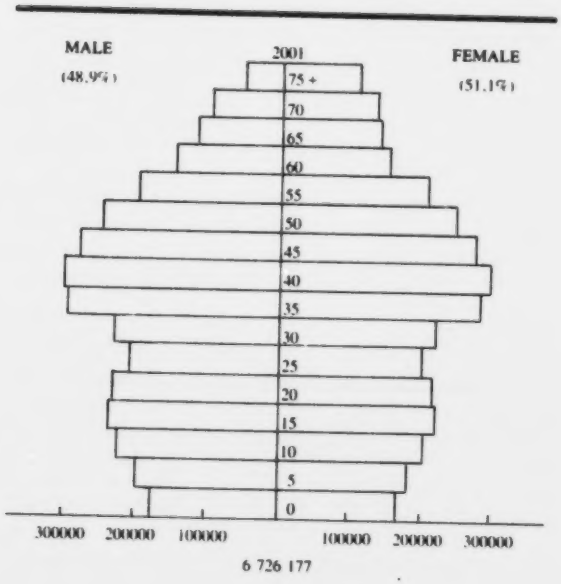
Dependency 70,2%



6 438 220

AGE	POPULATION (in 1 000s)	BREAK-DOWN
0 -14	1395	21.7%
14 -64	4474	69.5%
65 et plus	569	8.8%

Dependency 43,9%



AGE	POPULATION (in 1 000s)	BREAK-DOWN
0 -14	1143	17.0%
14 -64	4715	70.1%
65 et plus	869	12.9%
Total	6726	100.0%

Dependency 42,7%

Source: Direction de l'évaluation des programmes using census data from Statistics Canada, 1961, 1981. Results of a population projection using the SUPER-POP model.

December 1984

of the latter are quite different from those of the elderly. The proportion of people aged 65 or more will be close to 13% of the population in 2001, more than 60% of these people will be women.

Some Special Features

Almost 80% of Québec's inhabitants live in cities principally in the urban agglomerations of Montréal, Hull and Québec City. The rest of the population is dispersed over a vast, sparsely populated territory. This causes problems of accessibility to health care equal to that provided in large cities. Slightly over 80% of the population is French-speaking, about 11% is English-speaking and the remainder speaks various other languages. The 1981 census counted 46 850 Native people of which 85% are American Indians and 15% are Inuit. Unlike the American Indians who are dispersed over the whole of the province, Québec's Inuit inhabit the North.

Socio-economic characteristics

Income

In 1971, the average income was 4 969 $ compared to 12 457 $ in 1981 which represents a 125% increase over ten years. However, in constant dollars the rise is only 6%.

Average income differs markedly according to sex. In 1981, men's average income was 15 838 $ compared to 8 394 $ for women. In 1981, 16% of families were considered low-income families. This figure rises to 46% for single persons.

The Labour Market

Economic activity changed greatly during the 1971-1984 period. For example, the activity rate for persons aged 15 or over rose from 52,9% in 1971 to 61,5% in 1984. This increase is characterized by the massive arrival of women on the labour market. In effect, although the activity rate for men rose slightly (from 71,4% to 74,7%) the rate for women climbed from 35,0% to 49,1% over 10 years. Almost every second woman was in the labour market. In 1981, unemployment affected mainly young people with a rate of 20% for those under 25 years and 10% for others.

Schooling

Over the same period, the rise in the average level of schooling of Québec's population also contributed to changing its socio-economic profile. In 1971, 42% of those aged 15 or over had not finished 9th grade, whereas for 1981, this proportion fell to 26%. Furthermore, the number of persons having attended university was 13,5% in 1981 compared to 9,8% ten years earlier.

Suicide

Québec's suicide rate for persons aged 15-24 is close to that of the Federal Republic of Germany and greater than that of the United States, Japan, Sweden and most Western European countries.

From 1950 to 1980, the suicide rate among adolescents and young adults has increased nine-fold rising from 1,9 to 17,1 per 1 000 inhabitants. Currently, suicide ranks third (after road accidents and other accidents) as a cause of death for 15-24 year olds. It represents 16% of all deaths and 21% of mortalities through accidents and traumas. In 1979-1980, 4,5 times more young men aged 15 to 24 than young women of the same age took their lives. In 1950, the ratio was 2,5 male suicides for 1 female suicide.

According to a recent study, there are 3 to 5 times more suicide attempts in Québec than successful suicides (Charron, 1981). Suicide attempts are more common among adolescents and young adults than for older persons and more frequent among women than men.

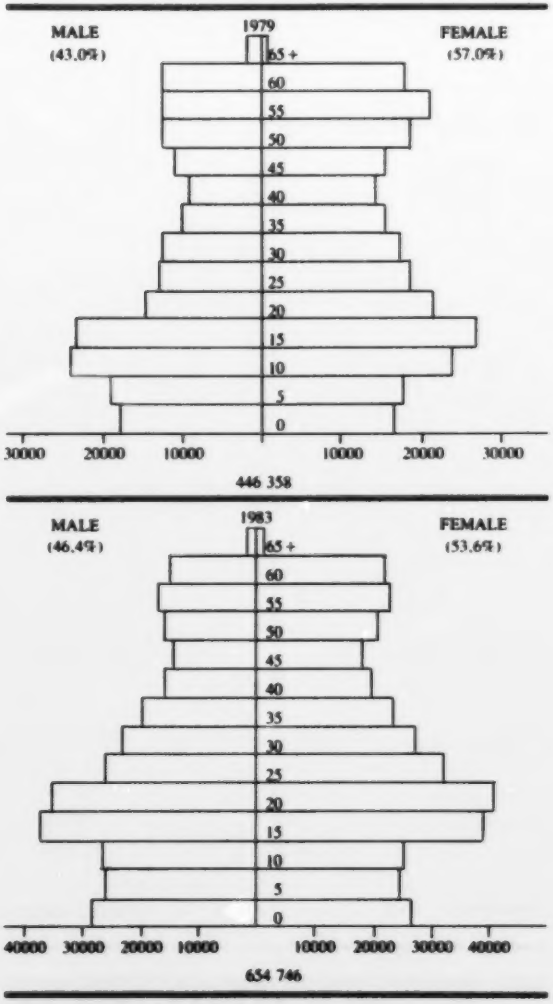
Marriages, Divorces and Single-Parent Families

In 1961, 92,7% of men and 87,1% of women got married compared to 57,1% and 57,9% respectively for 1984. In Québec, the number of marriages per 1 000 residents dropped from 7,3 marriages in 1978 to 5,9 in 1982. Corresponding figures for Canada as a whole are 7,9 and 7,6.

In the province of Québec, the number of divorces rose from 8,7 in 1969 to 44,0 in 1981. For every 1 000 people, divorces in Québec rose only slightly from 2,37 in 1978 to 2,87 in 1982. Remarriages counted for 14% of all marriages in 1981.

Single-parent families now represent 20% of all Québec families compared to 10% in 1971. Some 80% of sin-

Figure 2.2 Age Pyramids, Social aid beneficiairies, Québec, 1979, 1983



Source: Direction de l'évaluation des programmes.

December 1984

gle parents are women. The number of single-parent families receiving social aid rose by 51,3% from 1977-1984 and totalled 56% of all families registered for social aid in January 1985 (preliminary data).

The rise of common-law unions is similar to that of single-parent families. The percentage of common-law unions compared to legal unions is estimated at 20% for 1981 compared to 10% in 1971. Finally, extra-marital births rose to 18,2% of total births for 1982 compared to 3,1% in 1951.

Habits[1]

The habits or individual behaviour we most often designate as harmful to our health are : tobacco, alcohol abuse, lack of physical exercise, poor eating habits, drugs and psychotropic drugs.

Tobacco

In 1981, Québec took first place among industrialized countries for annual average tobacco consumption by adults. It hereby replaced the United States which had ranked first in 1975 despite the fact that since 1965, the percentage of smokers in Québec has constantly decreased. This trend is found especially for men, even young ones. In 1981, 44,9% of men smoked whereas 64,2% of them smoked regularly in 1965.

However, this trend has been quite different for women. The proportion of regular women smokers diminished only very little, if at all, over this period to settle around 33%. Young women now smoke more often than men of their age (48% of women between the age of 20 and 24 smoke regularly compared to 44% of men of the same age).

Strangely enough, this fall in the number of smokers has been accompanied by a rise in individual cigarette consumption. In 1970, a regular smoker consumed about 20,9 cigarettes daily. In 1981, this figure had risen to 26,2.

Tobacco consumption remains high for young people. In 1981, 32% of young Quebecers smoked regularly. This percentage is higher than in any other province. It is twice the number found for British Columbia. On the other hand, daily or occasional use of marijuana is lower in Québec for the population at large and for young people in particular then anywhere else in Canada.

Alcohol

From 1961 to 1976, alcohol consumption in Québec rose from 6,82 to 10,55 liters of pure alcohol per capita representing a 51% increase. Since this time, consumption has stabilized and has reportedly even dropped somewhat. This drop has affected mainly beer and spirits to some extent. However, the consumption of wine continues to increase.

In 1982, only New Brunswick's and Prince Edward Island's consumption was lower than Québec's. That of Alberta, the highest in Canada, was 36% higher than Québec's. Québec's position can be explained by the province's low consumption of spirits.

Among the various socio-professional categories, male professionals, teachers and doctors, compose the largest proportion of drinkers.

Women's behaviour differs. Women occupying management positions represent the greatest number of drinkers and also drink the most.

Thus, the habit of drinking regularly increases with social status. Nevertheless, those who drink the most are found in social groups whose working and living conditions are difficult. It has also been observed that alcohol consumption increases significantly with a person's level of stress.

American studies estimate that the overall cost of tabacco and alcohol, in terms of health care and production losses, represents about 25% of the overall economic cost of all illnesses. This would correspond to over two billion for Québec for 1981 divided fairly equally between tobacco and alcohol. However, if we add the social costs related to road accidents and problems of violence to this evaluation, the costs occasioned by alcohol are considerably higher.

Physical Activity

A lack of physical activity is generally associated with increased risk of cardiovascular problems. Being in good

(1) This section is taken from: OBJECTIF SANTÉ (Health as our Goal), Conseil des affaires sociales et de la famille.

physical shape improves the body's resistance and explains why people who do sports regularly need to go less often to the doctor's.

Levels of physical activity seem to be lower in Québec than the other provinces. In 1981, more sedentary people were found here than anywhere else in Canada. Apparently, 15% of persons aged 10 years and over in Québec are sedentary compared to 7% in British Columbia and the Prairies.

Nevertheless, rates have improved somewhat over the past 10 years. In 1974, only 18% of the population practiced a physical activity throughout the year whereas 28% were considered sedentary. In 1981, 57% of Quebecers practiced a physical activity at least 3 times a week 9 months a year and the proportion of sedentary people decreased by half. However, according to the ministère de la Santé et du Bien-être social, only one third of the population practices a physical activity at a level which is potentially beneficial to health.

Poor Eating

American studies recently proved conclusively that cholesterol constitutes a risk factor for cardiovascular diseases. Food which is too rich in fatty matter, especially fatty meat, encourages hyper-cholesteremia.

Québec is one of the world's largest meat consumers. Quebecers consume as much as the French, the Americans and more than other Canadians and Europeans. Since 1976, however, certain positive behaviour has evolved.

The consumption of fatty meats has decreased slightly at the expense of increased consumption of fresh and frozen vegetables. On the other hand, the consumption of legumes, cereal-based products and bread has not increased.

The consumption of sugar is directly related to dental cavities and indirectly related to obesity since the latter is linked to the consumption of foods which are excessively rich in calories. Among all O.E.C.D. countries, Québec is one of the largest consumers of sugar per capita.

Nevertheless, sugar consumption tendencies have reportedly been declining since 1976.

Psychotropic Drugs

According to Health Canada's 1978-1979 survey data, Quebecers consume more psychotropic drugs than Ontarians and other Canadians. Most vulnerable are middle-aged women and women who are alone at home or are social aid beneficiaries. After age 65, differences between men and women in this regard level out.

Groups outside the work force, the elderly and social aid beneficiaries consume many more psychotropic drugs on the average than the rest of the population. For these two groups, subscriptions for psychotropic drugs cost 8 300 000 $ and 700 000 000 $ respectively for 1981.

Furthermore, we know that consuming this type of medication creates a state of dependence which is difficult to escape for the person who falls into the pharmacological trap.

The harmful effects of psychotropic drugs are particularly evident among the elderly. Extended use of sleeping pills or tranquillizers can promote states of mental confusion or depression.

Health Characteristics

Life Expectancy

Since the early 1950s, life expectancy at birth has increased constantly in Québec. For men, it rose by 6,8% to reach 71,1 years in 1981. For women, it rose by 10,9 years attaining 79,2 years in 1981 (Figure 2.3 and Table 2.1). The same is true for life expectancies at various ages although changes are smaller and more regular. The increase in the life expectancy at 65 from 1976 to 1981 is particularly striking: it rose by one year for men and two years for women. This generalized upward movement creates the difference between male and female life expectancy.

Life expectancy is a general indicator which simply shows the average number of years of life at a given age according to the mortality rate observed over a given period. Another index, life expectancy with good health, permits us to balance these years of life by subtracting the sum of those years where activities are restricted (institutional, permanent or temporary) following illnesses or accidents. For example, for 1980, life expectancy with good

TABLE 2.1 Evolution in life expectancy and mortality, Québec, 1951 to 1981

INDICATORS	SEX	1951	1956	1961	1966	1971	1976	1981
Life expectancy at birth (in years)	M	64.3	66.2	67.1	67.8	68.4	69.0	71.1
	F	68.3	71.0	72.6	74.0	75.4	76.7	79.2
Life expectancy at one year	M	66.9	68.3	68.5	68.6	68.7	68.9	70.7
	F	70.2	72.6	73.7	74.6	75.5	76.5	78.8
Life expectancy at 35 years	M	35.8	36.7	36.6	36.8	36.9	37.0	38.6
	F	38.6	40.1	41.0	41.9	42.8	43.7	45.6
Life expectancy at 65 years	M	12.7	12.9	13.0	13.3	13.2	13.1	14.2
	F	13.9	14.7	15.1	15.8	16.6	17.1	19.1
Number of deaths	T	35 086	35 042	37 245	38 630	41 166	43 801	42 765
Gross mortality rate (per 1 000 inhabitants)	T	8.7	7.6	7.1	6.7	6.8	7.0	6.6

Source: Service des études et politiques de santé, M.A.S.
Registre de la population, M.A.S.
Direction de l'évaluation des programmes.
December 1984

health (at birth) was 59 years for men and 60.23 for women (Figure 2.4). More than 11 years for men and 18 for women include some form of restricted activity. The difference between the sexes, observed for mortality, thus practically disappears when we consider life expectancy with good health. Moreover, restricted activity increases rapidly with age and is severer for men than women.

Inequality before death exists not only between sexes but also between ethnic, professional and socio-economic groups. A study on mortality according to ethnic groups (Roy, 1975) shows that significant differences exist in Québec between Quebecers of French origin and those of other ethnic backgrounds (Table 2.2). The influence of socio-economic inequalities on the mortality of Quebecers of working age has also been studied. One such study is Billette's carried out in 1977. By setting the mortality for all men between 25 and 64 at 100, the relative mortality in the category including unskilled workers, farmers and day-workers is 144 compared to 85 in the professional and high-level executive category (Figure 2.5).

TABLE 2.2 Life expectancy at birth (in years) by sex and ethnic origin, Quebec, 1950-1952 to 1970-1972

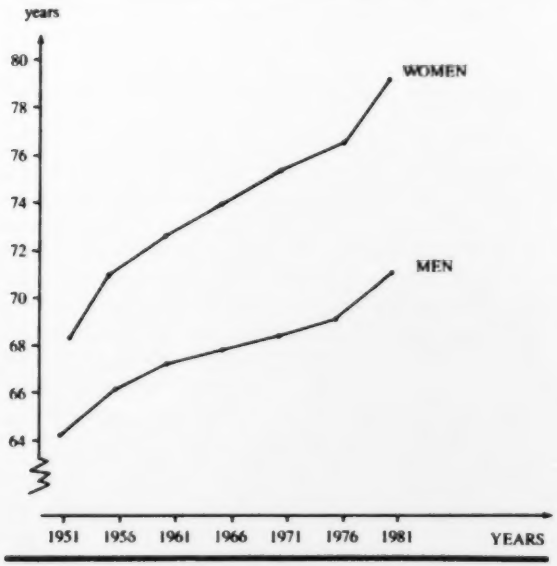
Period	Men		Women	
	French	Other	French	Other
1950-52	64.1	66.3	68.2	71.1
1960-62	67.0	68.8	72.5	74.3
1970-72	67.4	71.5	74.5	77.6

Source: Laurent Roy, *La mortalité selon la cause de décès et l'origine ethnique au Québec 1951, 1961, 1971, 1975.*

Principal Causes of Death

Heart disease, cancer, traumas and poisoning have increased significantly from 1951 to 1980 (Figure 2.6). In fact, 79,9% of all deaths occurring in 1979-1980 can be attributed to one of these three causes compared with 57% for the 1950-1952 period. In 1980, of every 10 people who died, five died of heart disease, two of cancer, one of

Figure 2.3 Evolution of life expectancy at birth in Québec from 1951 to 1981



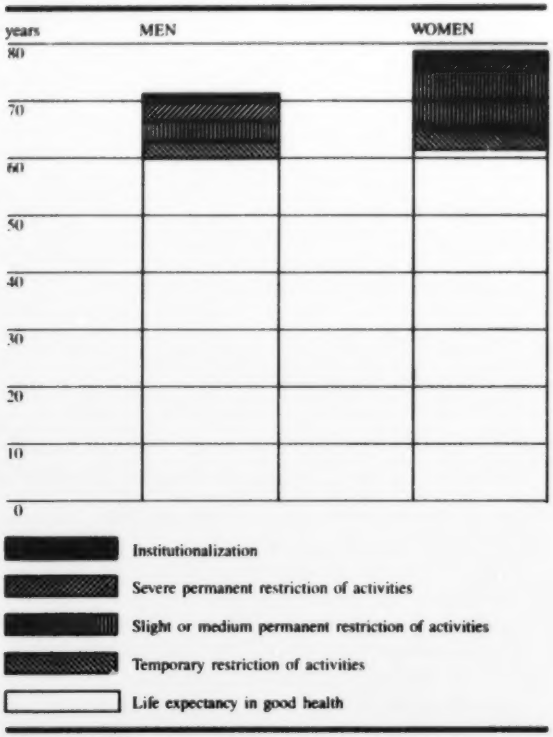
Source: Direction de l'évaluation des programmes. December 1984

traumas and poisoning and the last two of various other causes.

Principal Causes of Hospitalization

Table 2.3 shows the principal causes of short-term hospitalization in 1980 by main diagnoses, sex and age group. If we exclude those under one year and hospitalization following pregnancy, birth and any complications arising from them, we observe that the principal cause of hospitalization corresponds to respiratory diseases for young people from 1 to 14 years, mental problems for those 15 to 44 years and circulatory problems after 45 years. Note that diseases of the digestive system are among the top three causes of hospitalization regardless of the age group.

Figure 2.4 Total life expectancy and life expectancy in good health at birth by sex, Québec, 1980

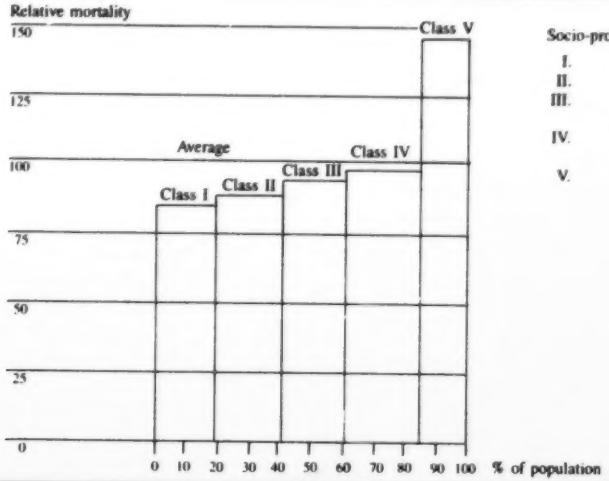


Source: Conseil des affaires sociales et de la famille.

Consultations in Outpatient Clinics

Table 2.4 shows the twenty most frequent diagnoses in 1983 for ambulatory patients. Among the most common reasons for seeing a doctor are: arterial hypertension, prevention, normal pregnancy, obesity, anxiety, acute infection of upper respiratory passages, otitis media, asthenia, grippe and diabetes. These diagnoses alone were responsible for more than 25% of all outpatient examinations in 1983.

Figure 2.5 Relative mortality for men aged 25-64 years by socio-professional category, Québec, 1974



Socio-professional category

I. Professionals, high-level executives
II. Technicians, middle management department heads
III. Employees specialized in administration and commerce, skilled unionized workers and their foremen
IV. Semi-skilled workers and their foremen, employees with some administrative and commercial skills
V. Unskilled workers, farmers, day labourers

Source: André Billette, *Les inégalités sociales de mortalité au Québec*, 1977

TABLE 2.3 Days of short-term hospitalization by main groups of diagnoses, sex and age group, Québec, 1980. (Rate per 1 000 inhabitants)

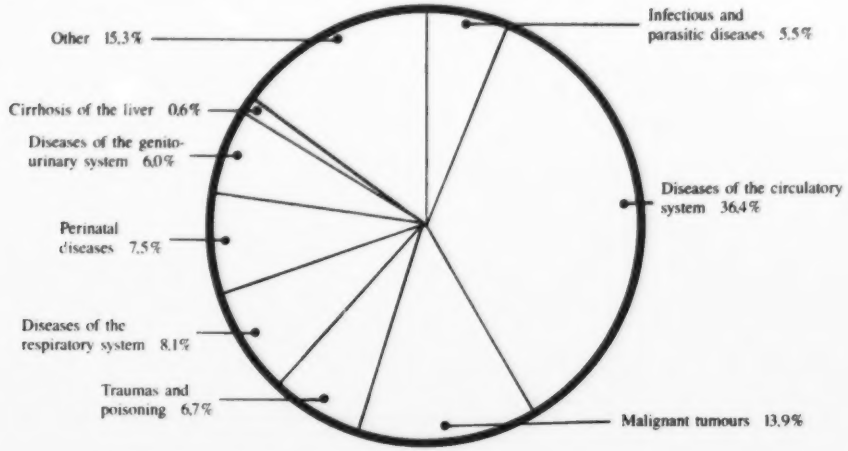
GROUPS OF DIAGNOSES	1 - 14		15 - 24		25 - 44		45 - 64		65 or over	
	M	F	M	F	M	F	M	F	M	F
Diseases of the respiratory system	61	45	21	23			89	54	384	197
Accidents, traumas, poisoning	43	23	101	34	76	35	101	67	235	352
Diseases of the digestive system	30	22	34	47	79	92	231	195	474	378
Mental problems	26	12	107	93	159	191	174	248	210	239
Congenital abnormalities	20	16								
Infectious and parasitic diseases	14	11								
Diseases of the nervous system	11	11	19	21						
Diseases of the sensory organs	11	9								
Diseases of the osteo-articulatory system			26	24	51	38	87	90	102	149
Diseases of the genito-urinary organs			3	34	19	150	77	140	323	135
Diseases of the circulatory system					50	39	413	228	1250	1041
Tumours							206	223	718	145
Endocrine, nutritional and metabolic diseases									102	156
Pregnancy, birth and complications				320		393				
Others[1]	72	67	77	91	130	216	217	228	528	505
TOTAL OF GROUPS	288	216	388	687	564	1155	1595	1473	4326	3597

(1) This category includes all other diagnoses and also those mentioned above for which no rate was given.

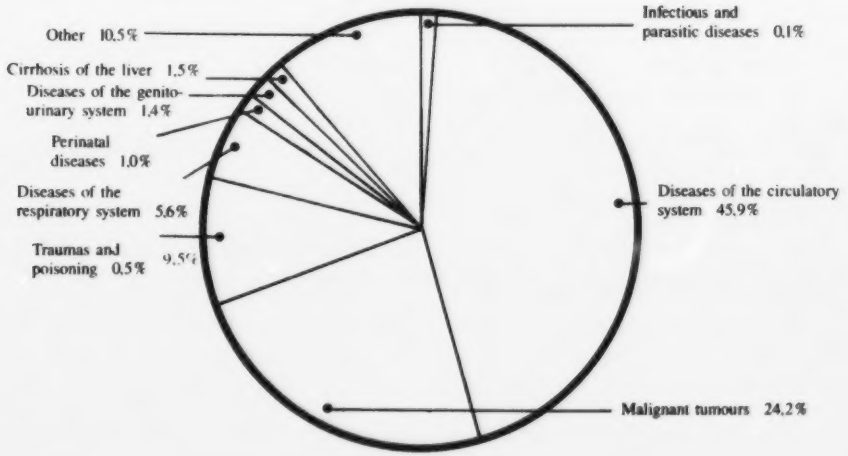
Source: Madeleine Levasseur, *Des problèmes prioritaires*, Conseil des Affaires sociales et de la famille, (Coll. La Santé des Québécois), 1984.

Figure 2.6

Break-down (%) of causes of death, Québec, 1950-1952


Other 15,3%
Infectious and parasitic diseases 5,5%
Cirrhosis of the liver 0,6%
Diseases of the genito-urinary system 6,0%
Diseases of the circulatory system 36,4%
Perinatal diseases 7,5%
Diseases of the respiratory system 8,1%
Traumas and poisoning 6,7%
Malignant tumours 13,9%

Break-down (%) of causes of death, Québec, 1979-1980


Other 10,5%
Infectious and parasitic diseases 0,1%
Cirrhosis of the liver 1,5%
Diseases of the genito-urinary system 1,4%
Perinatal diseases 1,0%
Diseases of the respiratory system 5,6%
Diseases of the circulatory system 45,9%
Traumas and poisoning 0,5%
Malignant tumours 24,2%

Source: Laurent Roy, *Des victoires sur la mort*, 1983

TABLE 2.4 The 20 most common diagnoses in examinations conducted in doctor's offices, at home, for patients registered with reception centres or extended care hospital centres, Régime de l'assurance-maladie, Pay by act, Québec, 1983.

DIAGNOSES		1983	%
Arterial hypertension	1	1 276 485	4.5
Prevention	2	1 176 378	4.2
Obesity	3	854 076	3.0
Normal pregnancy	4	833 235	3.0
Anxiety	5	662 966	2.4
Acute infection of the upper respiratory passages	6	601 346	2.1
Otitis media	7	575 439	2.0
Asthenia (fatigue)	8	484 956	1.7
Grippe	9	457 790	1.6
Diabetes	10	446 611	1.6
Supervision of new-borns or children	11	405 875	1.4
Acute pharyngitis	12	393 628	1.4
Dermatitis	13	387 192	1.4
Cervicitis and vaginitis	14	375 667	1.3
Indefinite bronchitis	15	358 975	1.3
Myopia, hypermetropia, presbyopia	16	345 148	1.2
Abdominal pains	17	343 257	1.2
Asthma	18	342 286	1.2
Contraceptive measures	19	342 284	1.2
Lumbago backache	20	337 156	1.2
Other diagnoses		17 118 908	60.9
TOTAL OF DIAGNOSES		28 118 652	100.0

Source: Unpublished data, Régie de l'assurance-maladie du Québec.

Direction de l'évaluation des programmes

Decembre 1984

3

THE SOCIOSANITARY SYSTEM

The System's Foundations

The principles upon which Québec's sociosanitary system are based are contained in the Act respecting health services and social services adopted in December 1971. It confers the following powers upon the ministère des Affaires sociales:

- improve the state of the population's health, the social environment it lives in and the social conditions of individuals, families and groups;
- make accessible to every person, continuously and throughout his entire life, a complete range of health services and social services including prevention and rehabilitation, so as to meet the physical, mental and social needs of individuals, families and groups;
- encourage the population and groups within it to participate in the introduction, administration and development of establishments in order to ensure their dynamism and renewal;
- better adapt health services and social services to the population's needs taking into account regional particularities and divide human and financial resources between these services as fairly and rationally as possible;
- encourage recourse to modern organization and management methods to increase effectiveness of services offered to the population;
- promote research and teaching.

Québec's system promotes a globalizing approach aimed at improving the state of the population's physical and mental health where people live while helping individuals, families and groups develop their self-sufficiency and assume all of their family and social responsibilities.

The ministère des Affaires sociales (MAS)

The ministère des Affaires sociales is responsible to the people for preparing and applying Québec's sociosanitary policies. It is charged with applying acts and regulations related to social affairs and public health. Thus, it must ensure that high-quality services are available to all citizens.

The Ministère is responsible for drawing up sociosanitary objectives, aims and priorities and for implementing the means necessary to accomplishing them, notably, organizing services and dividing budgets between the various establishments and regions after consulting regional health and social services councils.

The Ministère also plays an essential assessment and verification role. It evaluates the impact of programs offered and the performance of establishments and regional councils as well as controlling the application of acts and regulations and the regional use of resources.

The Ministère also participates in interdepartmental and intergovernmental coordination. It must make Québec's sociosanitary aims and objectives known to representatives inside and outside the network as well as to the population at large.

In 1985, five branches support the Ministère's activities: administration and systems information, labour relations, health, social services programs and budgetary and financial controls.

Furthermore, seven agencies come under the ministère des Affaires sociales' authority advising it or managing certain programs for it.

The Conseil des affaires sociales et de la famille

Created in 1970, the Conseil des Affaires sociales et de la famille is a study and consulting agency whose mandate is to advise the Minister in identifying objectives and priorities in the social affairs and family sector and to consult with the various groups and agencies involved in preparing social and family policies.

The Conseil consultatif de pharmacologie

The Conseil consultatif helps the Minister of Social Affairs in elaborating and updating the list of medication provided free of charge to social aid beneficiaries and the elderly. It also gives its opinion on the therapeutic value and price asked for each drug.

The Fonds de la recherche en santé du Québec

The Fonds is a non-profit organization. Created in 1981, it is responsible for allocating research bursaries and subsidies according to policies defined by the ministère des Affaires sociales.

The Corporation d'hébergement du Québec

Another non-profit organization, the Corporation was created in 1974. Its mandate is to ensure the construction of establishments as well as their financing for the ministère des Affaires sociales. Moreover, it periodically purchases certain buildings under the program for integrating private establishments.

The Comité de la santé mentale du Québec

Created in 1971, the Comité de la santé mentale du Québec's mandate is to cooperate with the Ministère in carrying out planning activities in the mental health sector.

The Conseil québécois de la recherche sociale

Composed of specialists from various humanities disciplines, the Conseil québécois de la recherche sociale advises the Minister on all matters pertaining to social research. It sets up and manages programs of subsidies for social research.

The Régie de l'assurance-maladie du Québec (RAMQ)

The Régie, the seventh agency under the authority of the ministère des Affaires sociales was set up in 1969. It manages several programs taking into account the provisions and agreements concluded between the Minister of Social Affairs and agencies representing health profes-

sionals participating in this plan. All Québec residents may take advantage of services insured by this plan, namely[1]:

- medical and surgical services;
- oral surgery performed in a hospital centre;
- optometric services;
- dental care for children under 16;
- dental care and dental prostheses for social aid beneficiaries;
- prostheses, orthopedic apparatus and their accessories and wheel chairs and certain other accessories;
- mammary prostheses;
- occulary prostheses;
- visual aids;
- hearing aids;
- apparatus for persons having undergone permanent stomies;
- aids for patients who have had their larynx removed.

Services provided outside of Québec are also insured and reimbursed to Québec beneficiaries based on rates in effect in Québec.

The RAMQ pays the various professionals involved in the health insurance plan. Remuneration take the form of rates by act performed, fees or wages according to the conditions determined in agreements concluded between the representative agencies and the Ministère. Billing beneficiaries over and above the amount covered by this plan is prohibited for physicians practicing in Québec.

Rate Clauses

Control mechanisms specific to Québec have been created to limit fee increases. Rate objectives or average annual income levels are set as well as individual income ceilings.

Rate objectives apply to physicians, whether general practitioners or specialists, and to optometrists. The rate objective is an average income forseen for a given period. If the average income is exceeded, rates for the subsequent period are adjusted so that the rate objective will be respected in the future. The target net average annual income level varies depending on the category of professional and the year.

Individual income ceilings apply to general practitioners and dentists. This measure consists of establishing an individual ceiling on a quarterly basis. Above this figure, fees paid are reduced by 75% for general practitioners and $66^2/_3$% for dentists.

Other provisions, set by law or negotiated agreements, are designed to better distribute staff throughout the province. These are incentive measures and remuneration differs. Introduced in 1982, incentive measures were addressed to physicians, general practitioners or specialists, and dentists to encourage them to practice their profession in outlying areas. They consisted of distance and isolation premiums, reimbursement of moving expenses and trips and professional resourcing.

The Social Affairs Network

To ensure all citizens of accessibility to high-quality care and services, the Act respecting health services and social services adopts an organizational model based on regionalization and the complementarity of establishments within the Social Affairs network. The establishments, numbering more than 800, are grouped by categories: hospital centres, reception centres, local community service centres and social service centres.

Regional Health and Social Service Councils (RHSSC)

The regional councils have become increasingly involved and constantly present in the establishment of a network of adequate, integrated health services and social services. In accordance with the Act respecting health services and social services, the regional council is responsible for:

- ensuring that the population's regional interests and needs are represented;
- ensuring that regions progressively take charge of organizing and utilizing sociosanitary resources and services;
- encouraging the population to participate in the administration and operation of establishments;

(1) We have listed services here to give a full picture of services which are insured. However, we have not mentioned exceptions, durations or specific information determining the type of services or beneficiaries by regulation.

- receiving and hearing users' complaints.

Thus, the regional council's task is to ensure that its region is provided with an integrated system of services corresponding to the population's needs, taking resources available into account. There are 13 regional councils each of which corresponds to one of Québec's sociosanitary regions.

Hospital Centres

Hospital centres are establishments to which people are admitted for preventive purposes, medical diagnosis, medical treatment and physical or mental rehabilitation.

Two classes of public hospital centres have been set up both for physical and mental illnesses:

- short-term care hospital centres (STCHC) which can nevertheless offer extended care to some of the beneficiaries staying there;
- extended care hospital centres (ECHC) which provide care and treatment on a continuous basis for an average period of more than 90 days.

A number of private hospital centres authorized by the State also exist. They are usually relatively small.

Health services provided in hospital centres are free of charge. They include meals and accomodation as well as all of the specialized services offered by modern hospitals. However, a hospital centre may claim certain fees for private or semi-private rooms and accomodation costs in the case of people receiving extended care.

Community Health Departments (C.H.D.)

A community health department is a department of a hospital centre. Some thirty hospitals, designated by the Ministère and distributed throughout the province, have these departments. The C.H.D. differs from other hospital departments in that it is community-oriented. Its purpose is to improve the health of the population in the area it serves. To accomplish this, it has a multidisciplinary team to do the following: study the state of the population's physical and mental health; draw up, with other establishments in its territory, programs for preventing illness and improving health; ensure that preventive and curative health services are available throughout the territory; coordinate health-related interventions and assess them.

The C.H.D.'s responsibilities are concretized as follows: epidemiological surveys, immunization, diagnosis of infectious diseases and epidemics, mother and child health care, school health, nutrition, dental health, health care for seniors citizens.

The C.H.D.'s sub-regional planning falls within regional planning done by the RHSSCs and is carried out in collaboration with various partners throughout its territory especially the L.C.S.C.s which are directly responsible for providing services to the public. Thus, the C.H.D. supports establishments in its territory in determining their priorities and objectives. However, these establishments continue to be in charge of organizing services and selecting the means to be implemented to attain program objectives.

Local Community Service Centres (L.C.S.C.)

The local community service centre is defined as follows in the Act: an establishment which, on a local basis, provides both preventive and curative health services and social services to the community as well as support services for organizing the community. L.C.S.C.s also receive people who do not need to be admitted to an establishment but who require health services or social services.

It advises people, provides them with the services required or, if necessary, directs them to resources better able to help them.

The following services and programs can be found in local community service centres:

- social services, especially in the school environment;
- community action services, by supporting agencies in the environment;
- marriage counselling services;
- intermediate health services;
- home care and help services;
- mother and child health care;
- school health;
- nutrition;

- birth control;
- industrial health;
- dental health.

These services are free of charge.

Social Service Centres (S.S.C.)

Social service centres are establishments offering free services to people faced with social needs like adaptation or protection. In areas where local community service centres do not yet exist, they also provide the services usually provided by establishments like the latter.

The S.S.C.'s mission is centred around four main axes:

YOUTH PROTECTION

Services offered within this framework are: social emergency, reception, assessment, counselling, social guardianship, placement in foster homes, placement in institutions, family counselling, expert advice for court situations, adoption;

PROTECTION OF ADULTS AND ELDERLY PEOPLE

Among the services offered to these recipients, we should mention: social emergency or stop-gap services, assessment, placement in foster homes, placement in institutions, support to the original family, psycho-social counselling;

INSTITUTIONAL SOCIAL SERVICES

These are social services in a hospital environment, services of expertise to the Superior Court and arbitration services in the Superior Court;

MINOR RESOURCES NETWORK

Whether we are dealing with foster homes or other private resources such as social protection homes, the social service centres are responsible for recruiting, assessing, accepting and ensuring the follow-up of resources. Certain fees may be exacted for children or adults lodged here.

Reception Centres (RC)

Reception centres are establishments offering in-house, out-of-house and home services for lodging people who are incapacitated, for maintaining them, keeping them under observation, treating them or permetting their social reintegration.

Home-care centres (HCC) receive people who, by reason of a lessening of their physical or psychological autonomy, usually due to old age, must stay in a protected residence.

There are also pavilions where services are offered to slightly incapacitated adults requiring food and shelter, supervision, aid and social protection. Contracts bind these pavilions to home-care centres.

Rehabilitation centres (RC) are addressed to four types of persons in particular: young people struggling with problems of social maladjustment, the mentally handicapped, the physically handicapped and alcoholics or drug addicts. The rehabilitation services offered by rehabilitation centres are provided for a limited time period and aim at socially integrating these people.

Fees are charged for all children or adults lodged in a reception centre. However, these depend on the user's ability to pay.

Community Organizations

The Ministère encourages the participation of volunteer community groups which work to improve the standard of living of their fellow citizens and their community by financing a number of volunteer organizations.

Volunteer Organizations for Home Treatment

In 1979, a subsidy program was begun. It was intended for volunteer organizations wishing to work in the field of home treatment for their deprived fellow citizens. In 1982-1983, the budget devoted to this purpose permitted supporting the action of 410 of these organizations.

Promotion and Family Services Organizations

These organizations work principally with isolated, abandoned groups and citizen having nowhere else to turn for help in alleviating their problems. In 1983-1984, 95 organizations benefitted from the Ministère's financial assistance.

Centres for Helping Women Experiencing Difficulties

These centres allow women with serious marital problems — sexual aggression, moral violence, physical abuse — to be lodged temporarily. Throughout 1983-1984, the

Ministère financed 38 centres which offered women accommodation and assistance when they were turned out of their homes, raped, mistreated, etc.

Youth Homes and Centres

Youth homes and centres, developed since 1977-1978, have become very active in the area of preventing juvenile delinquency and in rehabilitation. They also work towards developing young people's autonomy to permit them to face their individual or group problems. In 1983-1984, the Department subsidized 41 youth homes or centres.

Other Intervening Parties

- Offices of health professionals

  These private professional offices refer to places outside of establishments. One or more physicians, dentists or other professionals practice their profession, individually or as a group, privately and in their own businesses. Services provided here are insured by health insurance.

- Governmental Organizations

  Finally, there are many governmental organizations working with intervening parties from the Social Affairs network such as the Office des services de garde à l'enfance, the Office des personnes handicapées du Québec, the Commission de la santé et de la sécurité du travail du Québec and the Régie de l'assurance-automobile du Québec.

  Although this list of the main actors in Social Affairs is only a partial one, it shows that Québec has provided itself with an infrastructure and means of funding which permit reducing social or regional inequalities. Furthermore, other programs not mentioned in this chapter pursue the same objectives. Other intervening parties such as the media, universities and interest groups also contribute, through their comments and concrete actions, to orienting health and social security policies for the benefit of decision-makers and an improved standard of living for all Quebecers.

TABLE 3.1 Admissions in hospital centres by category of care and class of establishment, Québec, 1982-1983

CATEGORIES OF CARE Indicators	STCHC	ECHC	PSYHC	Total
SHORT-TERM CARE				
Number	707 209	1 248	11 907	720 364
Break-down (%)	98.8	8.5	75.2.	96.5
EXTENDED CARE				
Number	4 891	12 458	2 414	19 763
Break-down (%)	0.7	84.8	15.3	2.7
RECEPTION				
Number	3 889	988	1 510	6 387
Break-down (%)	0.5	6.7	9.5	0.9
TOTAL OF CATEGORIES				
Number	715 989	14 694	15 831	746 514

TABLE 3.2 Presence-days in hospital centres by category of care and class of establishment, Québec, 1979-1980 to 1982-1983

CATEGORY OF CARE Indicators	STCHC	ECHC	PSYHC	Total
SHORT-TERM CARE				
Number	7 282 362	52 719	623 318	7 958 399
Break-down (%)	78.6	1.1	18.9	46.4
EXTENDED CARE				
Number	1 396 863	3 861 230	1 760 390	7 018 483
Break-down (%)	15.1	83.8	53.5	40.9
RECEPTION				
Number	580 125	691 202	908 952	2 180 279
Break-down (%)	6.3	15.0	27.6	12.7
TOTAL OF CATEGORIES				
Number	9 259 350	4 605 151	3 292 660	17 157 161

TABLE 3.3 Persons lodged by sex and age group, Québec, 1982-1983

AGE GROUP Indicators	F	M	T
LESS THAN 18 YEARS			
Number	12	11	23
Break-down (%)*	52.2	47.8	100.0
Distribution (%)**	0.03	0.05	0.04
18 TO 64 YEARS			
Number	7 509	9 306	16 815
Break-down (%)*	44.7	55.3	100.0
Distribution (%)**	20.68	41.47	28.62
65 YEARS OR OVER			
Number	28 797	13 123	41 920
Break-down (%)*	68.7	31.3	100.0
Distribution (%)**	79.29	58.48	71.34
TOTAL OF AGE GROUPS			
Number	36 318	22 440	58 758
Break-down (%)*	61.8	38.2	100.0

* Break-down by sex
** Distribution by age group

TABLE 3.4 Presence-days in rehabilitation by category of reception centre, Québec, 1982-1983

CATEGORIES OF RECEPTION CENTRE Indicators	
RHC FOR THE PHYSICALLY HANDICAPPED	
Number	346 263
Break-down (%)	9.0
RHC FOR THE MENTALLY HANDICAPPED	
Number	1 812 305
Break-down (%)	47.2
RHC FOR THE SOCIALLY MALADJUSTED	
Number	1 273 569
Break-down (%)	33.1
RHC FOR ALCOHOLICS AND DRUG ADDICTS	
Number	89 110
Break-down (%)	2.3
HOMES FOR UNWED MOTHERS	
Number	43 082
Break-down (%)	1.1
OTHER	
Number	279 026
Break-down (%)	7.3
TOTAL OF CATEGORIES	
Number	3 843 365

TABLE 3.5 Utilization of services in health centres* by category of care, Québec, 1982-1983

CATEGORIES OF CARE Indicators	1982-83
SHORT-TERM CARE	
Number of admissions	6 781
Number of presence-days	47 219
EXTENDED CARE	
Number of admissions	149
Number of presence-days	99 995
RECEPTION	
Number of admissions	66
Number of presence-days	42 646
TOTAL OF CATEGORIES	
Number of admissions	6 996
Number of presence-days	189 860

* Health centres are former hospital centres usually located in regions far from large urban centres. They play the role of a LCSC.

TABLE 3.6 Beneficiaries of services provided by social service centres by type of service and categories of clientele, Québec, 1982-1983

TYPES OF SERVICES Category of clientele	Beneficiaires 31 March 82	New Beneficiaires	Beneficiaires 31 March 83
ADOPTION			
Children adopted legally	2 376	2 237	1 728
SOCIAL SERVICES TO CHILDREN AND FAMILIES			
Children placed	23 254	NA	18 989
Children monitored in natural environment	15 598	NA	17 194
SERVICES TO ADULTS			
Adults placed	9 827	N.D.	9 586
Adults monitored in natural environment	6 007	N.D.	5 925
SERVICES TO THE ELDERLY PLACED	5 639	NA	5 195
Monitored in natural Environment	8 011	NA	8 389
MARRIAGE COUNSELLING SERVICES			
Couples helped	1 357	1 552	972
SERVICES IN SCHOOLS			
Children taken charge of	6 080	8 645	6 056
SERVICES IN HOSPITALS			
Beneficiaires taken charge of	36 486	65 220	37 144
SOCIAL SERVICES TO NATIVE PEOPLES			
Beneficiaires taken charge of	1 891	668	1 850
SOCIAL SERVICES TO IMMIGRANTS AND TRAVELLERS			
Beneficiaries taken charge of	831	3 202	822
HOME CARE SERVICES			
Households benefitting from services	3 434	5 387	3 810

NA.: Not Available

* This figure represents the number of beneficiaries receiving services throughout the fiscal year (April 1 to 31 March)

TABLE 3.7 Number of participants and participation rate in programs managed by the Régie de l'assurance-maladie, Québec, 1983

PROGRAM	Number of Participants	Participation Rate*
		%
Medical services (all)	5 190 262	78,5
Dental services		
• Children (0-15 years)	822 632	55,8
• Social aid recipient (13 years or over)	178 925	34,6
• Oral surgery (all)	29 817	0,6
• Total of programs[1]	(1 010 711)	
Optometric services (all)	1 068 431	16,4
Pharmaceutical services		
• Social aid recipients	448 405	69,1
• Persons aged 65 or +	503 049	83,5
Prostheses and ortheses	25 130	0,08

(1) Since a person may benefit from services offered by several dental service programs over a year, the number of participants for all three programs is different from the sum of participants for each of these programs.

* The participation rate is defined as the ratio of the number of participants over the average number of corresponding beneficiaries (total population, children, social aid recipients, etc.).

TABLE 3.8 Number of partient-contacts* per resident, Health Insurance Plan, Pay by Act, Québec, 1983

	Men	Women
Under 5 years	6,9	6,2
5 – 14	3,3	3,2
15 – 24	3,1	5,5
25 – 34	3,4	6,9
35 – 44	3,9	6,5
45 – 54	4,9	7,2
55 – 64	6,9	7,9
65 or over	11,6	12,0
Total	4,8	6,7

* The number of patient-contacts is an indicator which distinguishes medical acts centred on contact with the patient from acts associated with this contact or which supplement it. It represents the sum of examinations, consultations, psychiatric treatments (psychotherapy) and surgical acts.

4

RESOURCES

This chapter deals with the question of human and material resources involved in providing health services and social services. Particular attention is paid to personnel (physicians, nurses, technicians, etc.) and establishments (hospital centres, number of beds, reception places, etc.). According to the nature of these data, figures will be analyzed in function of the number of inhabitants, the region and the environment.

Human Resources

Given the number and diversity of categories of personnel, the study of these resources is based on large groups such as professionals (in the large sense), technicians and nurses. These categories were determined according to sources of data available. However, in order to properly shed light on the subject, some examples of jobs will be given to illustrate each one of these categories. The presentation of human resources distinguishes two main groups[1]: health professionals paid by the Régie de l'assurance-maladie du Québec and all other resources within the network. This choice is basically linked to the sources of data we were able to use directly, namely, the Régie's files and the data bank of pay files of authorized public and private establishments in the Social Affairs sector.

Health Professionals Paid by the Régie de l'assurance-maladie du Québec

This study looks at four categories of professionals[2]: physicians, dentists, optometrists and pharmacists. These are the professionals who were paid by the Régie de l'assurance-maladie du Québec in 1983.

Physicians

In 1983, Québec had 12 117 physicians, or one for every 537 residents. Of this number, 6 200 were general practi-

(1) The presentation of specific categories within these two main groups is also a function of the data available. The fact that we present statistics on optometrists and denturologists without specifically dealing with dental hygienists and orthoptists, for instance, is essentially due to the availability of data.

(2) These figures are slightly less than the actual number of these professionals. However, professionals not counted are generally considered inactive in terms of providing care and services.

tioners and 5 917 were specialists. General practitioners enjoyed an average annual increase of 5,4% from 1973 to 1983 compared with 2,7% for specialists whereas the province's population rose by 0,79% annually over the same period.

Dentists

In 1983, 2 247 dentists and 41 oral surgeons provided dental care. Over the past five years, these two categories saw the personnel they employed increase by 3,6% and 2,6% annually, respectively. In 1983, there was one dentist for every 2 899 residents.

Optometrists

From 1973-1983, the number of optometrists rose by 3,6% annually from 570 to 809 optometrists. The optometrist/population ratio was one per 8 051 residents in 1983.

Pharmacists

Pharmacists owning their own pharmacy and registered with the Régie numbered 1 036 in 1983 whereas the overall number of pharmacists was 1 230 for the same year. However, we must remember that the former figure excludes salaried pharmacists. Furthermore, the Ordre des pharmaciens du Québec had 3 730 members at the end of the 1983 calendar year.

Overview by Geographic Distribution

This section presents the geographic distribution of the various categories of professionals paid by the Régie. We have compared their distribution to that of the population by dividing Québec into three large regions. This method has the advantage of simplifying the problem but it clearly masks the large difference which might be found within these regions.

The greater Montréal region comprises 42,1% of Québec's populationl. The second region includes zones bordering on the Montréal region as well as the Québec city and Estrie regions which can be qualified as urban zones and large regional centres of attraction containing 40,5% of the population. The third region covers the rest of the province, that is, the urban countries far from large centres, semi-rural and rural areas with 17,4% of the province's population.

Figure 4 shows the proportion of professionals to the population in these three regions. The region farthest from the large centres always has a lower proportion of professionals regardless of category but particularly for specialized physicians and specialized dentists. The peripheral region is under-represented in general practitioners, specialized physicians and dentists and over-represented in denturologists, optometrists and pharmacists. Finally, the Montréal urban agglomeration attracts a greater number of professionals than required by the population's distribution.

Salaried Personnel of the Social Affairs Network

There are more than 400 job titles in establishments within the Social Affairs network. These jobs are grouped into six main categories: nurses, other professionals, technicians, assistant technicians, office employees and workers. In 1982-1983, these categories included 129 072 people[1] divided over 793 establishments (hospital centres, reception centres, social service centres and local community service centres), (Table 4.1). These statistics do not include management personnel.

Management Personnel

In 1982-1983, there were 12 660 full-time executives or their equivalents. Almost half of them worked in short-term care hospital centres (Table 4.1b). Just under 80%, or 9 984, of these executives are middle management. High-level management comprises some 15% of all personnel.

(1) This is actually the number of salaried workers expressed in full-time equivalents. For example, for a job title whose regular work week is 35 hours, 1 820 hours of remuneration are necessary to equal a full-time equivalent. Nevertheless, to facilitate reading, we will refer to people rather than full-time equivalents.

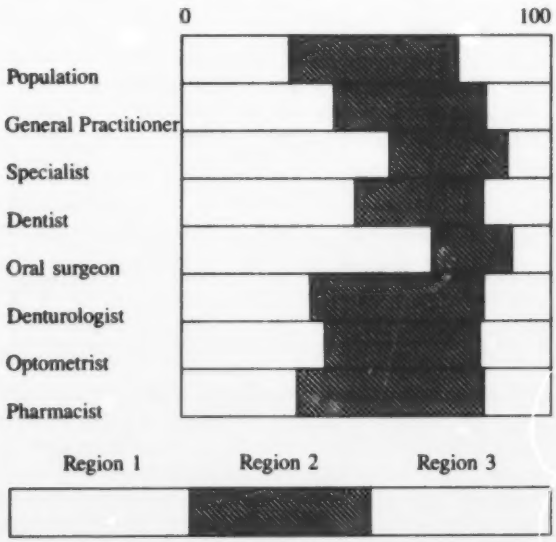
TABLE 4.1 Personnel which could be unionized[1] by class of establishment and job category, Québec, 1982-1983

	STCHC	ECHC	PSYHC	Private HC	LCSC[2]	SSC	RHC	HCC	Private RC	Total	%
Professionals	2 200	339	299	36	455	2 227	697	108	9	6 434	5,0
Technicians	7 261	338	1 068	104	508	1 257	4 558	185	150	15 466	12,0
Nurses	19 707	1 244	1 493	488	1 114	4	323	739	172	25 334	19,6
Technical Assistants	18 255	4 702	4 576	1 299	1 250	128	1 703	4 961	986	37 860	29,3
Office employees	11 908	864	1 030	228	828	884	987	631	122	17 674	13,7
Workers	13 246	2 902	2 294	636	470	40	2 396	3 745	564	26 304	20,4
Total of categories	72 577	10 389	10 760	2 791	4 625	4 540	10 664	10 369	2 003	129 072	100,0
Number of establishments	117	49	15	40	102	14	147	239	70	793	

(1) In full-time equivalence

(2) 12 of these are health centres

Figure 4.1 Distribution of population and health professionals by category of professional and region.



Region 1: Metropolitan Montréal

Region 2: Québec City, Estrie, Laurentide-Lanaudière and Montérégie

Region 3: Bas St-Laurent-Gaspésie, Saguenay-Lac St-Jean, Trois-Rivières, Outaouais, Abitibi-Témiscamingue, Côte-Nord and Nouveau-Québec.

TABLE 4.1b Break-down of executives by category of establishment and category of executive in terms of full-time equivalent, Québec, 1982-1983

	NON-EXECUTIVES*	UPPER MANAGEMENT	MIDDLE MANAGEMENT	TOTAL
STCHC	157	762	5 220	6 139
ECHC	51	188	845	1 083
Other HC	21	110	855	986
RHC	145	277	1 120	1 542
HCC	223	277	576	1 077
LCSC	100	34	359	492
SSC	16	86	659	760
RHSSC	19	30	91	140
Private HC	44	60	134	237
Private RC	67	12	124	203
TOTAL	842	1 834	9 984	12 660

* Directors general and their assistants

Source: Ministère des Affaires sociales, Service de soutien technique des relations de travail, for the period 1 April 1982 to 31 March 1983.

TABLE 4.2 Number of beds and places available by type of care and class of establishment, Québec, 1982-1983

	Short-term care beds	Extended care beds	Reception places	Total
STCHC	24 741	3 961	1 842	30 544
ECHC	198	11 073	2 151	13 422
PSYHC	1 847	5 073	2 599	9 519
LCSC	296	294	313	903
RHC	—	—	11 699	11 699
HCC	—	—	24 733	24 733
Total	27 082	20 401	43 337	90 820
% Rate	4,2	3,1	6,7	14,0

Nurses

To belong to this category, nurses must hold a practicing licence issued by the Ordre des infirmières et infirmiers du Québec. They numbered 25 234 in 1982-1983 and 90% of them worked in hospital centres. In fact, the great majority of nurses, 19 707, work in short-term care hospital centres. They represent close to 20% of all the network's personnel.

Other Professionals

This category includes employees holding a job generally requiring a university degree such as: physiotherapists, ergotherapists, psychologists, social workers and human relations agents. In 1982-1983, 6 434 people were employed in this category; they were concentrated mainly in short-term care hospital centres (2 200).

Technicians

Technicians usually hold a college degree. Despite the name given to this category, it does not include medical technologists or radiology technicians. It does include jobs like educators in reception centres and social aid technicians. In 1982-1983 once again, 15 466 people had this type of job; 7 261 of them worked in short-term care hospital centres and 4 558 in rehabilitation centres.

Technical Assistants

This category includes nurses aids and beneficiaries officers. These two job titles represent some 80% of all technical assistants. This was the largest group in 1982-1983 with 37 860 people, or almost 30% of all personnel. Once again, short-term care hospital centres employ most technical assistants (18 255). However, extended care hospital centres, psychiatric hospital centres and home-care centres also have a large number of technical assistants, namely, 4 702, 576 and 4 961, respectively.

Office Employees

In 1982-1983, 17 674 people were assigned to intermediate administrative duties. They were distributed more evenly throughout different categories of establishments. Although most (11 908) of them worked in hospital centres, between 800 and 1 000 worked in other types of establishments.

Workers

Maintenance, cooking, laundry and linen are some examples of the types of work practiced by the 26 304 workers counted in 1982-1983. They are found mainly in short-term care hospital centres although a significant number of them work in other types of hospital centres and reception centres.

Overview According to Category of Establishments

Excluding the professional and technician categories, short-term care hospital centres employ the majority of employees from the other categories. When we compared extended care hospital centres to psychiatric ones, we found almost the same number of employees in each category except that of technicians.

Social service centres are characterized by the number of professionals they employ, rehabilitation centres by the number of technicians (educators and social aid technicians). Home-care centres, on the other hand, employ mainly technical assistants (nurses aids and beneficiaries officers).

Material Resources

In order to illustrate the amount of material resources available, three indicators were selected: the number of establishments, the number of beds and the number of reception places according to the category of establishment.*

Establishments[1]

In 1982-1983, Québec had 221 hospital centres divided as follows: 117 for short-term care, 49 for extended care, 15

(1) These figures refer only to establishments which produced an annual financial report to the ministère des Affaires sociales. Therefore, even if several pavilions are connected to an institution, only the institution has been included in this calculation.

* We should mention again that the statistics given in this section are a function of the availability of data. For instance, selecting the number of reception places in an establishment does not take homes or foster homes into account.

for psychiatric care and 40 authorized private centres. There were also 456 reception centres including 239 home-care centres, 147 rehabilitation centres and 70 authorized private centres.

Beds and Reception Places

In 1982-1983, 27 082 short-term care beds were available to the population (4.1 beds for 1 000 inhabitants) compared with 20 401 extended care beds (3.1 beds for 1 000 inhabitants). More than 90% of short-term care beds are found in short-term care hospital centres whereas extended care beds are distributed mainly between extended care hospital centres (54%) and psychiatric hospital centres (25%). Furthermore, 43 337 reception places, or 6,7 for every 1 000 residents, were available or occupied. Accomodation centres offered double the number of places as rehabilitation centres, or 24 733 and 11 699 respectively.

In terms of the overall number of beds and reception places, most places (30 544) are found in short-term care hospital centres followed by home-care centres (24 733).

Material Resources and Geographic Distribution

Table 4.3 represents the number of establishments, beds and reception places by various classes of establishments and by the three regions into which Québec has been divided. Although the number of establishments is an interesting indicator in itself, we should be wary of comparing between regions since these establishments vary in size, purpose and resources. The number of beds and reception places becomes more pertinent in terms of the distribution of material resources.

This short profile does not do justice to the complexity of the social affairs network (its complexity adds to its fullness). Nevertheless, this summary permits us to present an overview of the social affairs network's resources.

TABLE 4.3 Number of establishments, beds and places prepared by class of establishment and region, Québec, 1982-1983

	STCHC	ECHC	PSYHC	LCSC	SSC	RHC	HCC	Total
Establishments								
Region 1	32	40	4	17	3	56	55	207
Region 2	46	36	5	41	4	67	162	361
Region 3	41	11	6	44	7	35	81	225
Total	119	87	15	102	14	158	298	793
Beds prepared[1]								
Region 1	11 200	5 885	3 907	—	—	—	—	20 992
Region 2	10 674	3 496	2 227	152	—	—	—	16 549
Region 3	6 828	1 890	786	438	—	—	—	9 942
Total	28 702	11 271	6 920	590	—	—	—	47 483
Reception places[1]								
Region 1	449	1 081	188	175	—	4 443	8 034	14 370
Region 2	1 094	476	1 945	78	—	4 906	12 999	21 498
Region 3	299	594	466	60	—	2 037	5 511	8 967
Total	1 842	2 151	2 599	313	—	11 386	26 544	44 835

(1) Beds or places with personnel and ready to receive a patient.

Region 1: Metropolitan Montréal

Region 2: cf. Figure 4.1

Region 3: cf. Figure 4.1

Direction de l'évaluation des programmes

February 1985

5

COSTS

In 1982-1983, the ministère des Affaires sociales spent 6,8 $ billion for the whole of its activities. This chapter details this amount according to centres of responsibility (hospital centres, LCSC, etc.) and fields of activity (preventive activities, diagnoses, etc.). Before dealing with these questions directly, a brief analysis will situate the size of costs related to social affairs among the whole of public spending.

Social Affairs and the Whole of Public Spending

Missions

In Québec, public spending is divided into four main missions: economic, educational and cultural, governmental and administrative and social. In 1984-1985, the **Crédits publics du Québec** anticipated spending 25,61$ billion for these four missions, that is, 25,5% of Québec's gross interior product (Table 5.1).

The social mission is the largest in terms of spending with 39,3% of the total or 10 $ billion (Figure 5.1).

Areas Included in the Social Mission

Spending related to the social mission is divided into three main areas: housing, income security, and health and social adjustment. The latter is the area corresponding most closely to the ministère des Affaires sociales' field of intervention. Compared to total costs devoted to the social mission, the health and social adjustment area represented 71,6%, or 7,2 billion (1 100 $ per inhabitant), of the total in 1984-1985 (Table 5.2 and Figure 5.2).

Sectors Included in the Area of Health and Social Adjustment

The health and social adjustment area is divided into four sectors, namely, prevention and improvement, health recovery, social rehabilitation and administration and services.

The first sector, prevention and improvement, is responsible for 4,7% of spending in the area of health and social adjustment (Figure 5.3). This sector includes spending related to LCSCs, supporting volunteer organizations and environmental protection. The second sector covers health, hospital centre services and the health insurance plan. This is the most expensive sector with 68,0% of the area's costs or 4,9 $ billion in 1984-1985 (Table 5.3). Social rehabilitation cost 1,8 $ billion or 24,6% of the area concerned. This sector includes spending in reception centres as well as public relations expenses and spending for the Office des personnes handicapées. The last sector, administra-

tion and services covers research coordination, regional and province-wide coordination, orientation and management of social affairs programs and the Office des services de garde à l'enfance. This sector only covered 2,7% of the health and social adjustment area in 1984-1985.

Spending by the ministère des Affaires sociales

The preceding section presented the evolution of social affairs spending according to principal sectors, areas and missions regardless of the Department involved. This section will be centred around the ministère des Affaires sociales' spending for the 1982-1983 fiscal year and will permit more detailed analysis of this spending according to the type of establishment or activity.

This spending analysis takes into account the amounts devoted to the Régie de l'assurance-maladie du Québec but excludes spending related to income security programs since these have come under the ministère de la Main d'oeuvre since 1981.

These expenditures will be presented in two ways: the first, more classic way, takes the type of establishment into consideration (that is, the centre of responsibility); and the second, by area of activities[1] allows us to distinguish the type of activity (preventive, diagnostic, therapeutic, etc.). Finally, a third section presents spending by the Régie de l'assurance-maladie du Québec by program.

By Type of Establishment

In 1982-1983, spending by the ministère des Affaires sociales reached 6,8 $ billion (Table 5.4). Short-term care hospital centres absorbed 44,6% of this amount (Figure 5.4), 3 $ billion or 465 $ per capita. Of this amount, 73% was designated for personnel's salaries. This represents the average wage proportion for all establishments varying from 70-80% depending on the type of establishment. The two other types of hospital centres, extended care and psychiatric, are responsible for 7,5% and 6,5% respectively of overall spending.

In 1982-1983, reception centres cost 952 $ million or 14,1% of total costs. This amount was distributed relatively equally among the two categories of reception centres, with

(1) Not to be confused with the overall areas given in the first section.

52,7% for rehabilitation centres and 47,3% for home-care centres. Social service centres represented 3,3% of the total compared to 2,9% for LCSCs.

Finally, the Régie de l'assurance-maladie's programs cost 1,3 $ billion or almost one fifth of total costs. The last section of this chapter presents the costs of the various programs managed by the Régie for the ministère des Affaires sociales.

Areas of activity[1]

For analysis purposes, nine areas were selected (the ninth is composed of activities not covered by the other eight categories). We can distinguish the following activities: preventive, diagnostic, therapeutic — either physical or mental — rehabilitation, support and protection, administrative and back-up activities (Table 5.5).

Preventive activities

These activities are related to programs and services aiming at the maintenance, promotion and improvement of individuals' or target-clienteles' physical or mental health whether in an institutional environment, in the workplace, at school or at home. Preventive activities include: promotion, education, supervision, detection, vaccination, immunization, information and control, especially in terms of perinatality, the school population and workers.

In 1982-1983, 125 $ million were devoted to these activities representing 1,9% of total costs (Figure 5.5).

Diagnostic activities

Two types of activities are related to this area:

- the preparation, registration and interpretation of data related to cardiac and neurological functions whether to aid instrumental exploration procedures or using radioactive substances and X-rays;
- sampling and sample analysis in order to determine the components and interpret the results.

These activities account for 8,0% of the total cost, that is, 538 $ million or 83 $ per inhabitant.

Physical Therapeutic Activities

These activities are related to providing nursing care and professional services in order to meet physical needs. This care may be provided to ambulatory patients whether in establishments, offices or at home or to patients requiring short-term care or extended care in the case of chronic care patients or convalescents.

This is the most expensive category with 30,4% of spending or more than 2 $ billion. This sum corresponds to an average cost of 318 $ per inhabitant.

Mental Therapeutic Activities

These activities are related to providing nursing care and professional services in order to meet psychiatric needs. They may be provided to ambulatory patients whether in day centres, foster families or elsewhere or to patients hospitalized for acute psychiatric illnesses in short-term psychiatric care units or for a long period in specialized psychiatric hospital centres.

In 1982-1983, these activities corresponded to 3,7% of total costs or 250 $ million.

Rehabilitation Activities

Three types of activities are included in this area:

Re-establishment of physical capacities

All activities related to counselling, rehabilitation and physical treatment of people suffering from physical, mental, visual or auditory deficiences. The object of these activities is to re-establish physical capacities or to attain maximum physical functioning.

Re-establishment of mental capacities

All activities related to counselling, rehabilitation and treatment of alcoholics, drug addicts, the mentally retarded or any other person suffering from mental problems whether

(1) These areas of activity were defined by grouping together centres of activities used in financial reports and by charging other expenses not included in these reports. They are operational definitions likely to change depending on the period or users' needs. The definitions proposed were being used by the Direction de l'évaluation des programmes when this document was written.

this be in outside counselling or the hospital environment to re-establish their weakened mental capacities or improve the psychological behaviour.

Re-establishment of social behaviour

All activities related to animation, information, education and psycho-social aid. They are directed towards individuals or groups to increase their autonomy, help them to solve their problems and overcome obstacles in their environment and permit them to participate in solving their socio-economic problems. Their aim is integration and social rehabilitation or improvement of social behaviour and functioning in a natural environment.

These rehabilitation activities cost 438 $ million in 1982-1983 or 68 $ per inhabitant. This amount represents 6,5% of total costs.

Support and Protection Activities

This area includes activities related to:

- aid services to persons and groups to maintain, preserve and develop their quality of life;
- daily assistance related to the welfare of beneficiaries in an establishment;
- assessment of non-institutional resources and taking charge of children (under 18 years) who have been abandoned or are victims of violence in order to provide them with substitute living conditions either permanently or temporarily or to promote their return to their natural environment;
- assessment of non-institutional resources and taking charge of adults (18 to 65 years) and the elderly (over 65), separated from their natural surroundings, in order to ensure their autonomy and provide them with adequate social protection;
- providing social services to Native Peoples in order to promote their autonomy and ensure them of adequate social protection.

With only 3,5% of total spending, the activities of this category cost 239 $ million.

Administration Activities

This area corresponds to all activities related to:

- overall administrative management of establishments and the administration and management of programs, professional and auxiliary services, and human, material and financial resources;
- improving the population's physical and psychological accessibility to services offered;
- conservation and development of hospital and medical financial data often using computerized equipment.

Administrative activities represent a large portion of spending, 14,3% for a total of 964 $ million.

Back-up Activities

This category includes activities related to:

- research and pilot project costs funded by private or governmental organizations;
- documentation, teaching, professional development and training of interns and residents and all other trainees in establishments;
- accommodation, including patient transportion, patient and staff food, laundry, linen, beds and household maintenance;
- operation of facilities, building maintenance and repair, security, parking lots, commercial transport, rent, etc.;
- equipment, charge on the debt and net increase of buildings.

This is the second most expensive area with 20,9% of total costs. These activities cost 1,4 $ billion in 1982-1983.

Programs Managed by the Régie de l'assurance-maladie du Québec

This section consists of a sort of supplement to the two sections preceding it. Considered as a centre of responsibility, the Régie manages programs touching on all areas of activity excluding support and protection services. The program concept and quality of data permit a specific presentation of the spending of this agency whose programs represented 20% of the Department's total costs in 1982-1983. The data given here correspond to the 1983-1984 fiscal year. Five programs hold our attention: medical,

optometric, dental and pharmaceutical services and the program devoted to prostheses and ortheses.

The medical services are by far the most costly with over 70% of the Régie's spending or 1.2 + billion (Table 5.6 and Figure 5.6).

In second place, we find the program of drugs and pharmaceutical services for social aid beneficiaries and elderly people aged 65 and over, with 10,9% of the total cost of programs managed by the Régie. Dental services cover the entire population for oral surgery performed in hospitals and more particularly, children under 16 and social aid beneficiaries who are covered for other services as well. These services cost more than 100 $ million in 1983-1984 representing 6,1% of the total. Optometric services exceeded 30 $ million but represented less than 2% of total costs. Finally, the prostheses and ortheses program cost 16 $ million or slightly less than 1% of all spending.

TABLE 5.1 Governmental spending by mission, Québec, 1984-1985.

MISSIONS Indicators	1984-85*
Economic mission	
Spending ($,000)	3 074 935
Per capita ($)	469.36
% GIP	3.05
Educational and cultural mission	
Spending ($,000)	7 445 653
Per capita ($)	1 136.50
% GIP	7.40
Social mission	
Spending ($,000)	10 087 213
Per capita ($)	1 539.71
% GIP	10.02
Governmental and administrative mission	
Spending ($,000)	5 032 199
Per capita ($)	768.11
% GIP	5.00
Total of missions	
Spending ($,000)	25 640 000
Per capita ($)	3 913.69
% GIP	25.47

* credits

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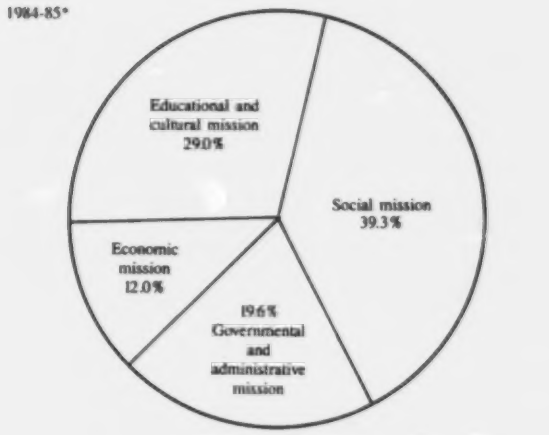
December 1984

FIGURE 5.1 Break-down of governmental spending by mission, Québec, 1984-1985



* credits

TABLE 5.2 Spending for social mission by main area, Québec, 1984-1985

MAIN AREAS Indicators	1984-85*
Income security	
Spending ($,000)	2 576 269
Per capita ($)	393.24
% GIP	2.56
Health and social adjustment	
Spending ($,000)	7 220 438
Per capita ($)	1 102.13
% GIP	7.17
Housing	
Spending ($,000)	290 506
Per capita ($)	44.34
% GIP	0.29

* credits

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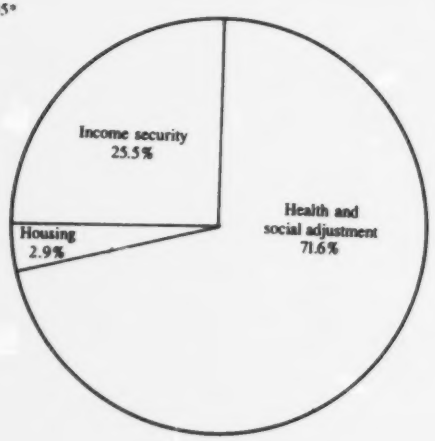
December 1984

FIGURE 5.2 Break-down of spending for social mission by main area, Québec, 1984-1985

1984-85*



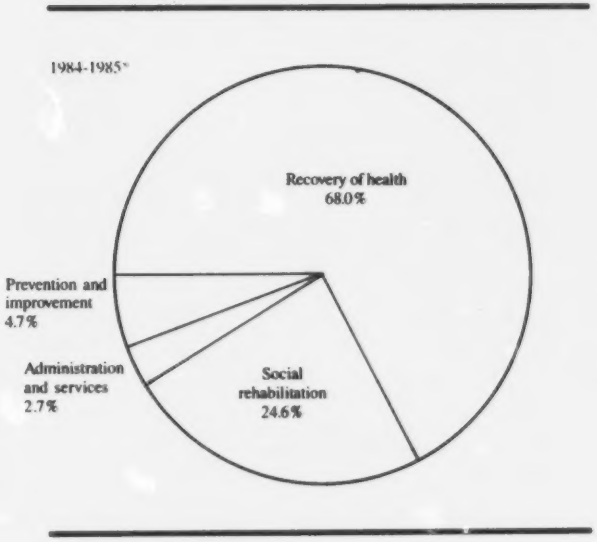
* credits

TABLE 5.3 Spending for health and social adjustment by main sector, Québec, 1975-1976 to 1984-1985

MAIN SECTORS Indicators	1984-85*
Prevention and improvement	
Spending ($,000)	340 718
Per capita ($)	52.01
% GIP	0.34
Recovery of health	
Spending ($,000)	4 908 354
Per capita ($)	749.21
% GIP	4.88
Social rehabilitation	
Spending ($,000)	1 773 504
Per capita ($)	270.71
% GIP	1.76
Administration and services	
Spending ($,000)	197 862
Per capita ($)	30.20
% GIP	0.20

* credits

FIGURE 5.3 Break-down of spending for health and social adjustment by main sector, Québec, 1984-1985



* credits

TABLE 5.4 Spending by the ministère des Affaires sociales by centre of responsibility, Québec, 1982-1983

CENTRES OF RESPONSIBILITY Indicators	1982-1983
STCHC	
Spending ($,000)	3 015 314
Per capita ($)	465,42
Index	156
ECHC	
Spending ($,000)	505 254
Per capita ($)	77,99
Index	199
PSY HC	
Spending ($,000)	379 890
Per capital ($)	58,61
Index	180
LCSC	
Spending ($,000)	198 565
Per capital ($)	30,65
Index	340
RAMQ	
Spending ($,000)	1 305 248
Per capital ($)	201,47
Index	156
SSC	
Spending ($,000)	221 194
Per capita ($)	34,14
Index	167
RHC	
Spending ($,000)	501 162
Per capital ($)	77,36
Index	180
HCC	
Spending ($,000)	451 254
Per capital ($)	69,65
Index	223
OTHERS	
Spending ($,000)	183 880
Per capital ($)	28,35
Index	62
TOTAL OF CENTRES OF RESPONSIBILITY	
Spending ($,000)	6 761 370
Per capital ($)	1 043,43
Index	161

Figure 5.4 Break-down of spending by the ministère des Affaires sociales by centre of responsibility, Québec, 1982-1983

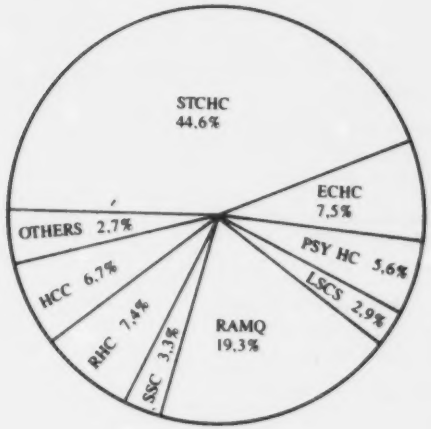
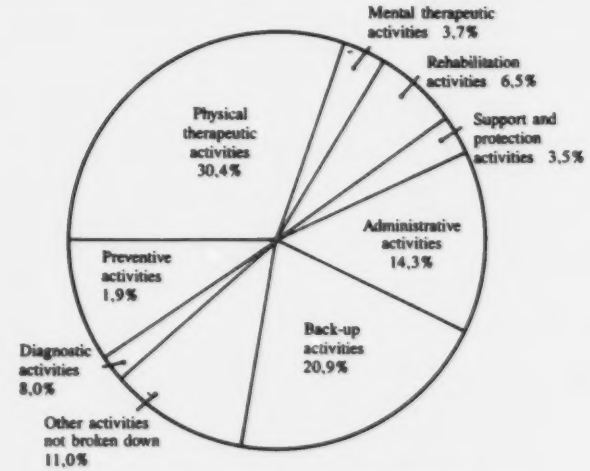


TABLE 5.5 Spending by the ministère des Affaires sociales by area of activity, Québec, 1982-1983

AREAS OF ACTIVITY Indicators	1982-83
Preventive activities	
Spending ($,000)	125 001
Per capital ($)	19,29
Diagnostic activities	
Spending ($,000)	537 776
Per capita ($)	83,01
Physical therapeutic activities	
Spending ($,000)	2 057 259
Per capital ($)	317,54
Mental therapeutic activities	
Spending ($,000)	250 001
Per capital ($)	38,59
Rehabilitation activities	
Spending ($,000)	437 619
Per capital ($)	67,55
Support and protection activities	
Spending ($,000)	239 097
Per capital ($)	36,91
Administrative activities	
Spending ($,000)	963 547
Per capita ($)	148,73
Back-up activities	
Spending ($,000)	1 409 788
Per capita ($)	217,60
Other activities not broken down	
Spending ($,000)	741 283
Per capital ($)	114,42
TOTAL OF AREAS OF ACTIVITY	
Spending ($,000)	6 761 370
Per capital ($)	1 043,63

Figure 5.5 Break-down of spending by the ministère des Affaires sociales by area of activity, Québec, 1982-1983



Direction de l'évaluation des programmes

December 1984

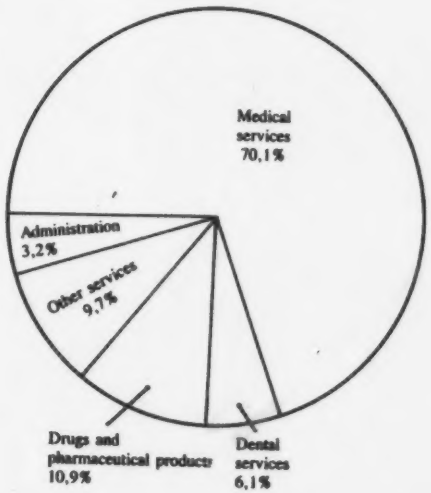
TABLE 5.6 Spending devoted to the Health Insurance Plan by program provided, Québec, 1983-1984

PROGRAMS PROVIDED Indicators	1983-84
Medical services Spending ($,000)	1 149 213
Optometric services Spending ($,000)	30 825
Dental services Spending ($,000)	100 418
Drugs and pharmaceutical services Spending ($,000)	178 411
Prostheses and ortheses Spending ($,000)	16 166
Other services Spending ($,000)	112 525
Administration Spending ($,000)	53 023
TOTAL OF PROGRAMS PROVIDED BY RAMQ Spending ($,000)	1 640 581

Direction de l'évaluation des programmes

December 1984

Figure 5.6 Break-down of spending by the Régie de l'assurance-maladie by program provided, Québec, 1983-1984



Direction de l'évaluation des programmes

December 1984

6

APPENDICES

List of Tables

Chapter 2

TABLE 2.1 Evolution in life expectancy and mortality, Québec, 1951 to 1981

TABLE 2.2 Life expectancy at birth (in years) by sex and ethnic origin, Québec, 1950-1952 to 1970-1972

TABLE 2.3 Days of short-term hospitalization by main groups of diagnoses, sex and age group, Québec, 1980

TABLE 2.4 The 20 most common diagnoses in examinations conducted in doctor's offices, at home, for patients registered with reception centres or extended care hospital centres, Health Insurance Plan, Pay by act, Québec, 1983.

Chapter 3

TABLE 3.1 Admissions in hospital centres by category of care and class of establishment, Québec, 1982-1983

TABLE 3.2 Presence-days in hospital centres by category of care and class of establishment, Québec, 1979-1980 to 1982-1983

TABLE 3.3 Persons lodged by sex and age group, Québec, 1982-1983

TABLE 3.4 Presence-days in rehabilitation by category of reception centre, Québec, 1982-1983

TABLE 3.5 Utililization of services in health centres by category of care, Québec, 1982-1983

TABLE 3.6 Beneficiaries of services provided by social service centres by type of services and categories of clientele, Québec, 1982-1983

TABLE 3.7 Number of participants and participation rate in programs managed by the Régie de l'assurance-maladie, Québec, 1983

TABLE 3.8 Number of patient-contacts per resident, Health Insurance Plan, Pay by Act, Québec, 1983

Chapter 4

TABLE 4.1 Personnel which could be unionized by class of establishment and job category, Québec, 1982-1983

TABLE 4.1b Break-down of executives by category of establishment and category of executive in terms of full-time equivalent, Québec, 1982-1983

TABLE 4.2 Number of beds and places available by type of care and class of establishment, Québec, 1982-1983

TABLE 4.3 Number of establishments, beds and places prepared by class of establishment and region, Québec, 1982-1983.

Chapter 5

TABLE 5.1 Governmental spending by mission, Québec, 1984-1985

TABLE 5.2 Spending for social mission by main areas, Québec, 1984-1985

TABLE 5.3 Spending for health and social adjustment by main sector, Québec, 1975-1976 to 1984-1985

TABLE 5.4 Spending by the ministère des Affaires sociales by centre of responsibility, Québec, 1982-1983

TABLE 5.5 Spending by the ministère des Affaires sociales by area of activity, Québec, 1982-1983

TABLE 5.6 Spending devoted to the Health Insurance Plan by program provided, Québec, 1983-1984

List of Figures

Chapter 2

FIGURE 2.1 Age pyramids, Québec, 1961, 1981, 2001
FIGURE 2.2 Age pyramids, Social aid beneficiaries, Québec, 1979, 1983
FIGURE 2.3 Evolution of life expectancy at birth in Québec from 1951 to 1981
FIGURE 2.4 Total life expectancy and life expectancy in good health at birth by sex, Québec, 1980
FIGURE 2.5 Relative mortality for men aged 25-64 years by socio-professional category, Québec, 1974
FIGURE 2.6 Break-down (%) of causes of death, Québec, 1950-1952

Chapter 4

FIGURE 4.1 Distribution of population and health professionals by category of professional and region

Chapter 5

FIGURE 5.1 Break-down of governmental spending by mission, Québec, 1984-1985
FIGURE 5.2 Break-down of spending for social mission by main area, Québec, 1984-1985
FIGURE 5.3 Break-down of spending for health and social adjustment by main sectors, Québec, 1984-1985
FIGURE 5.4 Break-down of spending by the ministère des Affaires sociales by centre of responsibility, Québec, 1982-1983
FIGURE 5.5 Break-down of spending by the ministère des Affaires sociales by area of activity, Québec, 1982-1983
FIGURE 5.6 Break-down of spending by the Régie de l'assurance-maladie by program provided, Québec, 1983-1984

List of Acronyms used

a/c	Activity centre
BSQ	Bureau de la Statistique du Québec
CHD **(DSC)**	Community Health Department **Département de santé communautaire**
ECHC **(CHSLD)**	Extended care hospital centre **Centre hospitablier de soins de longue durée**
FT	Full-time
FTE	Full-time equivalent
GIP	Gross Interior Product
HCC **(CAH)**	Home-care centre **Centre d'accueil d'hébergement**
LCSC **(CLSC)**	Local community service centre **Centre local de services communautaires**
MAS	Ministère des Affaires sociales
OIIQ	Office des infirmières et infirmiers du Québec
PSY HC **(CH PSY)**	Psychiatric hospital centre **Centre hospitalier à vocation psychiatrique**
PT	Part-time
RAMQ	Régie de l'assurance-maladie du Québec
RHC **(CAR)**	Rehabilitation centre **Centre d'accueil de réadaptation**
RHSSC **(CRSSS)**	Regional health and social service council **Conseil régional de santé et de services sociaux**
RREGOP	Régime de retraite des employés du gouvernement et des organismes publics
SSC **(CSS)**	Social service centre **Centre de services sociaux**
STATCAN	Statistics Canada
STCHC **(CHSCD)**	Short-term care hospital centre **Centre hospitalier de soins de courte durée**
TC **(CAT)**	Transition centre **Centre d'accueil de transition**

Statutes administered by the Minister of Social Affairs

Act respecting the ministère des Affaires sociales,
R.S.Q., c. M-23

Act respecting the Conseil des Affaires sociales et de la famille,
R.S.Q., c. C-57

Act respecting health services and social services,
R.S.Q., c. S-5

Health Insurance Act,
R.S.Q., c. A-29

Act respecting the organization of the management and union parties in view of collective bargaining in the sectors of education, social affairs and government agencies,
R.S.Q., c. 0-7.1

Act respecting the Régie de l'assurance-maladie du Québec,
R.S.Q., c. R-5

Hospital Insurance Act,
R.S.Q., c. A-28

Youth Protection Act,
R.S.Q., c. P-34.1

Mental Patients Protection Act,
R.S.Q., c. P-41

Burial Act,
R.S.Q., c. I-11

Non-Catholic Cemetaries Act,
R.S.Q., c. C-17

Act approving the Agreement concerning James Bay and Northern Québec,
R.S.Q., c. C-67

Act approving the Northeastern Québec Agreement,
R.S.Q., c. c-67.1